MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

04161

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Fruitland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles C. Ball

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Bertha Ball

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Sept. 24 1864

8. AGE: Years	Months	Days	If less than one day
81	6	1	....hrs. ....min.

9. Birthplace: Fruitland md.
(Town, county and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: William Ball

FATHER — 13. Birthplace: Fruitland, md

MOTHER — 14. Maiden name: Elizabeth Livingston

MOTHER — 15. Birthplace: Fruitland, md.

16. Informant: Mrs. Alton Ball

Address: Fruitland, md

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) April (day) 29 (year) 1946

Cemetery or crematory: Friendship Cmtery

Location: East Princess Anne

18. Funeral director: Charles Dashiell

Address: Princess Anne md.

19. (Date rec'd by registrar) 4/27 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26, 1946, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Hypertensive Cardio-	
Due to Vascular Heart	2
Disease -	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury Injured at work?

23. SIGNATURE: Le L. Lawry M.D.

M. D. or other

Address: Fruitland Date signed 4-27-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

dr. cohn

04162

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Stockton Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ballard Barbara Ann

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	C	single

6.(b) Name of husband or wife

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17 1941

8. AGE: Years 4 | Months 10 | Days no | If less than one day: hrs. 10 mo. min.

9. Birthplace stockton md Worc. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name artie Ballard

13. Birthplace stockton md

MOTHER 14. Maiden name Emma Wallop

15. Birthplace hurntown va

16. Informant artie baland

Address stockton md

17. Buried (Burial, cremation, or removal. Which?) Date thereof apr. 18. 1946 (month) (day) (year)

Cemetery or crematory old Saint Pauls

Location Near Stockton md

18. Funeral director Irvin Bennett

Address Stockton md

19. 4/30, 1946. Harriet L. Johnson (Registrar)

(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1946 at 9 10 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death TB meningitis — DURATION 1 wk

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

16 of april died Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should he charged statistically.

22. VIOLENCE: If death was due to external causee, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Owen M.D. M. D. or other

Address Snow Hill Date signed 4/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

04163

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Wicomico
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lavenia C. Bennett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Single

8.(b) Name of husband or wife
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 3 - 1855

8. AGE: Years 90 | Months 8 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace: Sharptown Wic Md (Town, county, and state)
10. Usual occupation: House work
11. Industry or business:

FATHER
12. Name: William T. Bennett
13. Birthplace: Md

MOTHER
14. Maiden name: Rachel A. Robinson
15. Birthplace: Md

16. Informant: Cora S. Bennett
Address: Sharptown

17. Burial (Burial, cremation, or removal, which?) Date thereof 4-17-1946 (month) (day) (year)
Cemetery or crematory: M. P. Cemetery
Location: Sharptown

18. Funeral director: Graveson Bros
Address: Sharptown

19. Apr 17 1946 (Date rec'd by registrar) Walter A. Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/14 1946, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 1945 to 4/14 1946 and that I last saw h ex alive on 4/14/46 1946

Immediate cause of death	DURATION
Chronic Cardio Renal	7 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H. D. Kuhlman M. D. or other
Address: Sharptown Md Date signed 4/17/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

04164

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Peninsula General

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? One day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Delia Barnie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	

6.(b) Name of husband ~~or wife~~: Henry Barnie

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct-15-1870

8. AGE: Years: 75 | Months: 6 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Illinois
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER — 12. Name: James Stillwell
13. Birthplace: Ills.

MOTHER — 14. Maiden name: Kennedy Stillwell
15. Birthplace: Ill.

16. Informant: Guy Sharp

Address: 3 Reb St Wilmington Del

17. Burial (Burial, ~~cremation~~, or removal. Which?) Date thereof Apr. 22, 1946 (month) (day) (year)

Cemetery or crematory: St. Andrews

Location: Princess Anne Md

16. Funeral director: P M Smith

Address: Princess Anne.

19. 4/20/1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1946, at 12.45 A M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19 to 19

and ~~that I last saw him~~ alive on 19

Immediate cause of death	DURATION
Burned to death	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 4/19/46

Where did injury occur? Princess Anne (City or town) Somerset (County) Md (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury: Burned Injured at work? Yes

23. SIGNATURE: Drew M. Lankford M. D.

M. D. or other

Address: Princess Anne Md Date signed 4/20/46

DREW M. LANKFORD, M.D.
Deputy Medical Examiner
Somerset County

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

CERTIFICATE OF DEATH

04165 Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred: Peninsula General Hosp.

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Worcester

City or town: Fruitland (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Bounds, Miss Beatrice B.

3.(b) Social Security Number: 212-03-1456

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Single

6.(b) Name of husband or wife: ✓

6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): Dec. 1, 1892

8. AGE:

Years	Months	Days	If less than one day
53	5	16	hrs. min.

9. Birthplace: Fruitland, Wicomico, Md. (Town, county, and state)

10. Usual occupation: Retail Bank Cashier

11. Industry or business: Banking

FATHER
12. Name: W. Jones Bounds
13. Birthplace: Wicomico Co., Md.

MOTHER
14. Maiden name: Miss Mitilla Milone
15. Birthplace: Wicomico Co., Md.

16. Informant: Mrs. Vera V. Powell

Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/20/46 (month) (day) (year)

Cemetery or crematory: Allen, Methodist

Location: Allen, Md.

18. Funeral director: De Vaul & Johnson Co.

Address: Salisbury, Md.

19. 4/20, 1946 (Date rec'd by registrar) Maggie L. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17, 1946, at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-4, 1946, to 4-17, 1946, and that I last saw h.e.r. alive on 4-17-46, 19

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions: Chronic Cholecystitis	

(Include pregnancy within 3 months of death)

Major findings of operations: Cholecystitis & Cholelithiasis. Date of op. 4-8-46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos. A. Finch M.D. (M. D. or other)

Address: Salisbury, Md. Date signed: 4-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04166

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Wicomico Co

City or town: Fruitland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred: Parsonage street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Fruitland (If outside city or town limits, write RURAL and give nearest town)

Street No. Parsonage street (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mattie Bozman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 15-1870

8. AGE: Years 75 | Months 4 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace Eden Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business at Home

FATHER 12. Name John Bozman

FATHER 13. Birthplace Wicomico Maryland

MOTHER 14. Maiden name Martha Jackson

MOTHER 15. Birthplace Wicomico Maryland

16. Informant Mrs. Minnie McDaniel

Address R.D. #1. Salisbury Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 8 1946 (month) (day) (year)

Cemetery or crematory Allen Church Cem.

Location Allen Maryland

18. Funeral director Hollowa & Co. Walter R. Hollowa

Address Salisbury Maryland.

19. 1/8/1946 (Date rec'd by registrar) Bessie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6th 1946 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Rademacher MD Deputy Med. Exam. Wic. Co. M. D. or other

Address Salisbury Md Date signed 1/8/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04167

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury R.F.D. #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Born here
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury R.F.D. #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Annie Burris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	Married

6.(b) Name of husband or wife: Julius Burris
6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): Dec. 5, 1911

8. AGE: Years	Months	Days	If less than one day
34	4	19	hrs. min.

9. Birthplace: Accomac Co. Va. (Belle Haven)
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Luther Palmer
13. Birthplace: Belle Haven, Va.
MOTHER 14. Maiden name: Lester Belle Haven
15. Birthplace: Belle Haven, Va.
16. Informant: Julius Burris
Address: Salisbury R.F.D. #2 Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2 '46 (month) (day) (year)
Cemetery or crematory: Quantico Cemetery
Location: Quantico Md.
18. Funeral director: David D. Messick
Address: Hebron Md.
19. 5/2/ 19 46. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 19 41 at 5 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19
Immediate cause of death: Probably Tuberculosis of Pulmonary

DURATION
4 mos

Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: For Rodney Laker M.D.
Deputy Med Examiner
M. D. or other
Address: Salisbury Md. Date signed 4/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

C4168

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Lifetime
Hospital, institution, or street address where death occurred: 305 E. Isabella St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 305 E. Isabella St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Cora C. Carter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Alonzo F. Carter
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Nov. 18-1869

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
76	4	14		

9. Birthplace: Salisbury Maryland (Town, county, and state)
10. Usual occupation: Home wife at home
11. Industry or business

FATHER
12. Name: James Connelly
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Mrs. Elsie Bailey
Address: Hebron Md. R 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5-46 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.

19. April 15 1946 Cassie E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2nd 1946 at 10:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1941 to 4-2 1946
and that I last saw h.e.r. alive on March 21 1946

Immediate cause of death	DURATION
Acute cardiac failure	
Due to: Cardio vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Nature of injury: Injured at work?

23. SIGNATURE: [illegible] M.D. M. D. or other
Address: Salisbury Md. Date signed 4-3-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

C4169

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hrs
Hospital, institution, or street address where death occurred:
P. G. Hospital
How long in hospital or institution? 24 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Mardela, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Gula L. Catlin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Ira U. Catlin
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): May 7 1874

8. AGE: Years	Months	Days	If less than one day
71	10	13	hrs. min.

9. Birthplace: Sussex Co. Del
(Town, county, and state)
10. Usual occupation: Home work
11. Industry or business

FATHER
12. Name: Major D. Bradley
13. Birthplace: Del

MOTHER
14. Maiden name: Delila Cooper
15. Birthplace: Del.

16. Informant: Ira U. Catlin
Address: Mardela, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 23 1946 (month) (day) (year)
Cemetery or crematory: Mardela
Location: Mardela, Md

18. Funeral director: Graveson Bros
Address: Sharptown

19. 4/23 1946 (Date rec'd by registrar) Isaac E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1946, at 11:45 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3/18 1946, to 4/20 1946 and that I last saw h[illegible] alive on April 20 1946

Immediate cause of death	DURATION
Chronic Valvular Disease of Heart	10 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. S. Kuhlman M. D. or other
Address: Sharptown Md Date signed 4/23/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (146)

04170

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, Institution, or street address where death occurred: P. B. Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For new-born infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 136 Penna. Ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Beulah Anita Cimino

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Samuel Cimino

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): April 17th 1915

8. AGE: Years: 31 | Months: — | Days: 3 | If less than one day: hrs. min.

9. Birthplace: White Haven Maryland (Town, county, and state)

10. Usual occupation: Home Wife

11. Industry or business: at Home

FATHER — 12. Name: Edward Malone

FATHER — 13. Birthplace: Somerset Co. Maryland

MOTHER — 14. Maiden name: Jennie Elizabeth Martin

MOTHER — 15. Birthplace: Somerset Co. Md.

16. Informant: Mr. Samuel Cimino

Address: 136 Penna. Ave. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 23 1946 (month) (day) (year)

Cemetery or crematory: Wi Co. Mem. Park

Location: Salisbury Maryland

18. Funeral director: Holloway & Walter R. Holloway

Address: Salisbury Maryland

19. 4/23/46 (Date rec'd by registrar) Maggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 20 1946 at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 16 1946 to Apr. 20 1946 and that I last saw h[illegible] alive on Apr. 20 1946

Immediate cause of death	DURATION
Pulmonary Embolism	
Due to	
Due to	
Other conditions: Post Partum, 4 days; Uncomplicated Normal Spontaneous Delivery (Include pregnancy within 3 months of death)	

Major findings of operation: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Stivers Hauson, M.D. (M. D. or other)

Address: Salisbury Md Date signed: 4/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

04171

Reg. Dist. No. 323

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hosp

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No.: East
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Robert Lance Coffin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 29 1946

8. AGE:

Years	Months	Days	If less than one day
		3	____ hrs. ____ min.

9. Birthplace: Salisbury Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Isaac Coffin
13. Birthplace: Delmar Del.

MOTHER
14. Maiden name: Marguerite Albin
15. Birthplace: Delmar, Del.

16. Informant: Isaac Coffin
Address: Delmar Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-2-46 (month) (day) (year)
Cemetery or crematory: Gy. P.
Location: Delmar Del.

18. Funeral director: W. S. Hyland Co
Address: Delmar Del.

19. 4/2/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1 1946 at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 March 1946 to 1 April 1946 and that I last saw him alive on 1 April 1946

Immediate cause of death	DURATION
Prematurity	3 days
Due to	
Due to	
Other conditions: Bilateral Pulmonary atelectasis	3 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

(Signature) Alex Kites, M.D.
M. D. or other

Address: 221 E. Camden Ave. Salisbury, Md. Date signed: 2 April 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

04172

Reg. Dist. No. 333

Dr. Howson.

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 6 hrs 38 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State < County <

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war <

3.(a) FULL NAME Congdon - Baby Boy -

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

B.(b) Name of husband or wife <

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 9 - 1946

8. AGE: Years | Months | Days | If less than one day: 6 hrs. ..... min.

9. Birthplace Salisbury Wicomico Md
(Town, county, and state)

10. Usual occupation <

11. Industry or business

FATHER 12. Name Robert L. Congdon

13. Birthplace Ohio

MOTHER 14. Maiden name Majorie L. Stewart

15. Birthplace Pennsylvania

16. Informant Mr Robert L Congdon

Address Snow Hill, Md

17. Burial (Burial, cremation, or removal, which?) Date thereof April 12 46 (month) (day) (year)

Cemetery or crematory Episcopal

Location Snow Hill, Md

18. Funeral director Hearne & Dennis

Address Snow Hill, Md

19. 4/12 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 April 19 46, at 2 50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-9 19 46, to 4-9 19 46

and that I last saw h alive on 19

	DURATION
Immediate cause of death Congenital Pulmonary Atelectasis	5 hours
Due to Prematurity	5 hours
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M.D.
M. D. or other

Address Salisbury, Md. Date signed 4/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Wade

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

Reg. Dist. No. 11-1723 29

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Worcester

City or town Girdletree (If outside city or town limits, write RURAL and give nearest town)

Street No. R. 7. D. #1 (If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Davis, Mrs. Annie E.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife James K. Davis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 22 - 1866

8. AGE:

Years	Months	Days	If less than one day
80	2	3	..... hrs. ..... min.

9. Birthplace Girdletree Worcester Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER — 12. Name William Farr

13. Birthplace Maryland

MOTHER — 14. Maiden name Harriett Stuges

15. Birthplace Maryland

16. Informant Mr. Deane R. Davis

Address 2500 E. Winona Ave. Norwood Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 28 1946 (month) (day) (year)

Cemetery or crematory Spring Hill

Location Girdletree, Md

18. Funeral director Deane & Dennis

Address Snow Hill, Md

19. 4/28/46 (Date rec'd by registrar) Maggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1946, at 6:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1946 to April 25 1946 and that I last saw her alive on April 25 1946

Immediate cause of death ..... DURATION

(a) Pneumonia .....

Due to ....

....

Due to ....

....

Other conditions ....

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. H. Neely M. D. or other

Address Salisbury Date signed 4/26/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Hanson -

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

04175

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 27 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Somerset

City or town Pocomoke City (If outside city or town limits, write RURAL and give nearest town)

Street No. Rt # 1 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Davis-Betty

3.(b) Social Security Number

4. Sex: Female

5. Color or race: C

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: George Davis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 1901

8. AGE: Years 45 Months Days If less than one day ..... hrs. ..... min.

9. Birthplace: Halifax County North Carolina (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER 12. Name: Thomas Ponton

13. Birthplace: North Carolina

MOTHER 14. Maiden name: Carolina Edmonds

15. Birthplace: North Carolina

16. Informant: George Davis

Address: Pocomoke City, Md Rt #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 13 1946 (month) (day) (year)

Cemetery or crematory: Halls Hill Cemetery

Location: Pocomoke City, Md

18. Funeral director: H. Harvey Bielstein

Address: Pocomoke City, Md

19. April 13 1946 (Date rec'd by registrar) Anne E. Twilley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1946 at 3.15

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 6 1946 to Apr. 9 1946

and that I last saw her alive on Apr. 9 1946

Immediate cause of death: Syphilitic Heart Disease — DURATION

Due to:

Due to:

Other conditions: Myocardial Hypertrophy

(Include pregnancy within 3 months of death)

Major findings of operation: none — Date of op.

Autopsy results: confirmatory

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

D. Rivers Hanson, M.D.

M. D. or other

Address: Salisbury, Md Date signed 4/10/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

C4176

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred: R.D. #2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new-born infants give residence of mother)
State: Md. County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mollie Jane Dennis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Handy Dennis
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Aug. 30-1879

8. AGE: Years: 66 | Months: 7 | Days: 4 | If less than one day: hrs. min.

9. Birthplace (Town, county, and state): Parsonsburg Maryland
10. Usual occupation: Home Wife
11. Industry or business: at Home

FATHER
12. Name: Richard Richardson
13. Birthplace: R.D. Pittsville Maryland

MOTHER
14. Maiden name: Mary Parker
15. Birthplace: Parsonsburg Md.

16. Informant: Mr. J. Handy Dennis
Address: R.D. #2 Pittsville Maryland

17. Burial (Burial, cremation, or removal, which?) Date thereof April 7-1946 (month) (day) (year)
Cemetery or crematory: Pittsville Cem.
Location: Pittsville, Maryland

18. Funeral director: Hillman & Walter R. Hoffman
Address: Salisbury Maryland

19. (Date received by registrar) 4/7/46 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4th 1946 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Coronary occlusion	Sudden death.
Due to: chronic Myocarditis	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. A. Rademaker M.D. Deputy Medical Examiner
M. D. or other
Address: Salisbury Md. Date signed: 4/5/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

Dr. Hanson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

04177

CERTIFICATE OF DEATH

Reg. Dist. No. 233

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 Wicomico
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Dorrell- George Albert

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 23-1946

8. AGE: Years | Months | Days | If less than one day ..... hrs. ..... min.
/

9. Birthplace: Salisbury Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Geo. albert Leonell
13. Birthplace: Salisbury, Md.

MOTHER
14. Maiden name: Eleanor Carey
15. Birthplace: Keyport, N.J.

16. Informant: Geo. Albert Leonell
Address: Salisbury Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof 4-25-46 (month) (day) (year)
Cemetery or ~~crematory~~: M. P.
Location: Leland Del

18. Funeral director: W. S. Ingram & Co
Address: Delmar Del

19. 4/26/46 (Date rec'd by registrar) 19 46 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24 1946, at 4 55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 23 1946 to Apr. 24 1946 and that I last saw h.im alive on Apr. 24 1946

Immediate cause of death	DURATION
Prematurity	
Due to: Premature Labor	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: J. Rivers Hanson, M.D.
M. D. or other
Address: Salisbury, Md Date signed 4/24/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Yeaman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1246)

04178

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred: R.D. #2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hattie M. Driscoll

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 26th 1872

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
74	—	16		

8. Birthplace: Wango, Md. (town, county, and state)
10. Usual occupation: At Home
11. Industry or business:
FATHER 12. Name: John L. Driscoll
13. Birthplace: R.D. Salisbury Md.
MOTHER 14. Maiden name: Mary Jane Dennis
15. Birthplace: Stuts Down, Md.
16. Informant: Miss Rosie Driscoll
Address: R.D. #2 Salisbury Md
17. Burial, cremation, or removal (Which?): Burial — Date thereof: Apr. 16-1946 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.
18. Funeral director: Hellen & G. Walter R. Holloway
Address: Salisbury Maryland.
19. 4/16/1946 (Date rec'd by registrar) Harold E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1946 at 8:55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3 1946 to April 12, 1946.
and that I last saw her alive on April 12, 1946.

Immediate cause of death	DURATION
Cirrhosis of Liver.	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Injured at work?
Means of injury:

23. SIGNATURE: John N. Yeaman M.D.
M. D. or other
Address: 230 Camden Ave Salisbury, Md.
Date signed: April 12 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 445

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04179

Reg. Diat. No. 233

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 3 hrs.

Hospital, Institution, or street address where death occurred:
Peninsula Gen. Hospital.

How long in hospital or institution? About 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Delaware County: Kent

City or town: Dover
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Dover Army Airfield.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II (Was still in Service)

3.(a) FULL NAME: Duke, Walter G.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	(Married)

6.(b) Name of husband or wife: Betty Ann Elliott Duke

6.(c) If alive, give age: 19 years

7. Birth date of deceased (mo., day, yr.): 10 Dec 1921

8. AGE:

Years	Months	Days	If less than one day
24	4	4	....hrs. ....min.

9. Birthplace: Greenwood, Del.
(Town, county, and state)

10. Usual occupation: Soldier U.S. Army.

11. Industry or business: —

FATHER
12. Name: Charles Richard Duke
13. Birthplace: Virginia

MOTHER
14. Maiden name: Juliet WYNN
15. Birthplace: Richmond Virginia.

16. Informant: Wife of Deceased & Army Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 17-1946 (month) (day) (year)
Cemetery or crematory: Odd Fellows
Location: Seaford - Delaware

18. Funeral director: Mrs. Julia Wyatt Boyer
Address: Harrington, Delaware

19. 6/8/1946 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 April F 1946, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Accidental Examination & Report 19..., and that I last saw him alive on Admission to Hosp. 14 Apr. 1946

Immediate cause of death	DURATION
Internal Hemorrhage	
Due to Fractured Pelvis, Severe	
Contusions of Body	
Due to Aircraft Accident	
Other conditions Fract rt. wrist, "	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Aircraft Accident. Date of: 14 April '46

Where did injury occur? (Near) Pittsville (City or town), (County), Md. (State)

Injured at home, farm, industry, public place (where?): In Woods.

Means of injury: Aircraft Accident Injured at work? Yes

23. SIGNATURE: Clara T. Fisher M.D. or other
Deputy Medical Examiner
Address: Salisbury, Md. Date signed: 4/14/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(4180)

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Worcester

City or town Near Pittsville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Pearl Dukes.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married.

8.(b) Name of husband or wife Henry Dukes.

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 1886

8. AGE:

Years	Months	Days	If less than one day
60	8	6	hrs. min.

9. Birthplace Ocean City Md.
(Town, county, and state)

10. Usual occupation House work.

11. Industry or business

FATHER — 12. Name John Downing

13. Birthplace Ocean City Md.

MOTHER — 14. Maiden name Elizpena Downing

15. Birthplace Ocean City. Md.

16. Informant Pearl Bull

Address Pittsville. Md.

17. Burial. Date thereof April 17 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fair Green Cemetery.

Location Berlin Md.

18. Funeral director Wm. Howard Wells

Address Pittsville. Md.

19. 4/17 1946 Received by Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15th 1946 at 3.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1944 19 to April 14, 1946 19

and that I last saw h alive on April 14, 1944 19

	DURATION
Immediate cause of death Myocarditis	
Chronic	2 yrs.
Due to Hypertension	1
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank L. Lewis M.D.
M. D. or other

Address Pittsville Md. Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

04181

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Parkwalkin md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Parkwalkin
(If outside city or town limits, write RURAL and give nearest town)

Street No. rd
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME James Elgy

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a a	Married

6.(b) Name of husband or wife: Mary A Elgy

6.(c) If alive, give age: yes years

7. Birth date of deceased (mo., day, yr.): — — 1888

8. AGE: Years: 57 Months: — Days: — If less than one day: hrs. min.

9. Birthplace: Quantico md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Same as above

FATHER 12. Name: James Elgy

FATHER 13. Birthplace: Quantico md

MOTHER 14. Maiden name: Josephine Manns

MOTHER 15. Birthplace: Parkwalkin

16. Informant: Mrs Mary Elgy

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May (month) 1 (day) 1946 (year)

Cemetery or crematory: Parkwalkin

Location: Parkwalkin md

18. Funeral director: James F. Stewart

Address: Salisbury md

19. 5/1/46 (Date rec'd by registrar) Clarence E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 April 1946, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 April 1946 to 26 April 1946 and that I last saw h. alive on 26 April 1946

	DURATION
Immediate cause of death: Cerebral apoplexy	23 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arthur L. Browne M.D. M. D. or other

Address: Salisbury Md Date signed: 4/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

04182

Reg. Dist. No. 233

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 304 Dock St
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME Samuel Gale

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	widower

6.(b) Name of husband or wife: Annie Gale

Dead 6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1869

8. AGE: Years	Months	Days	If less than one day
about 77			hrs. min.

9. Birthplace: Quantico md
(Town, county, and state)

10. Usual occupation: was a Laborer when worked

11. Industry or business: same as above

FATHER 12. Name: Henry Gale

13. Birthplace: Quantico md

MOTHER 14. Maiden name: Kathleen Hammon

15. Birthplace: Quantico md

16. Informant: Daniel Gale

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 26 1946 (month) (day) (year)

Cemetery or crematory: Quantico md

Location: Quantico md

18. Funeral director: James R. Stewart

Address: Salisbury md

19. 4/25 1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1946 at 6:08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12 1946 to April 20 1946 and that I last saw him alive on April 20 1946

Immediate cause of death	DURATION
Cardiac Decompensation	8 days
Due to: Renal Hypertension	
Due to: Glomerulo Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of Injury: Injured at work?

23. SIGNATURE: J. Pennell M.D
M. D. or other

Address: 200 W. Main Salis. Date signed: 4-24-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

04183

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, institution, or street address where death occurred: P.B. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 214 W. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sewell Emory Griffin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie Mae Griffin
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Nov. 30-1889

8. AGE:

Years	Months	Days	If less than one day
56	5	—	...hrs. ...min.

9. Birthplace: R.D. Berlin Md. (Town, county, and state)
10. Usual occupation: Prop of Restaurant
11. Industry or business:

FATHER
12. Name: Edward Griffin
13. Birthplace: R.D. Berlin Md.

MOTHER
14. Maiden name: Rose Timmons
15. Birthplace: R.D. Berlin Md.

16. Informant: Mrs. Annie M. Griffin
Address: 214 West Main St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4-1946 (month) (day) (year)
Cemetery or crematory: Wic. Mem. Park
Location: Salisbury Md.

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.

19. 5/4/1946 (Date rec'd by registrar) Bessie L. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1946 at 11-25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 to April 30 1946
and that I last saw h... alive on April 30 1946
Immediate cause of death: Cerebral Hemorrhage — DURATION

Due to: Arteriosclerosis
Due to: Hypertension

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Manner of injury: Injured at work?

23. SIGNATURE: Geo. A. Fuller M. D. or other
Address: Salisbury Md. Date signed 5/3/1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

04184

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred: Peninsula Presbyterian Conv., Broad St.
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 707 East Division
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Margaret Todd Grier

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Ralph W. Grier ✓
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Sept. 14, 1888

8. AGE:

Years	Months	Days	If less than one day
57	7	16	...hrs. ...min.

9. Birthplace: Salisbury, Wicomico, Md. (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business: ✓

FATHER
12. Name: Henry L. Todd
13. Birthplace: Salisbury, Md.

MOTHER
14. Maiden name: Agnes Phelps
15. Birthplace: Maryland

16. Informant: Ralph W. Grier
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/8/46 (month) (day) (year)
Cemetery or crematory: Parsons
Location: Salisbury, Md.

18. Funeral director: The Wells Johnson Co.
Address: Salisbury, Md.

19. (Date rec'd by registrar) 5-13-1946 Lessie C. Johnson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30, 1946, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19... and that I last saw h... alive on ...19...

Immediate cause of death: Coronary Occlusion — DURATION: sudden death.
Due to: ✓
Due to: ✓
Other conditions: ✓
(Include pregnancy within 3 months of death)

Major findings of operation: ✓ Date of op. ✓
Autopsy results: ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ✓ Date of ✓
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ✓
Means of injury ✓ Injured at work? ✓

23. SIGNATURE: Chas. T. Grier M.D.
M. D. or other
Address: Salisbury Md. Date signed 5/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

04185

Reg. Dist. No. 3 0 9 9

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Years

Hospital, institution, or street address where death occurred:
John B. Parsons Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. John B. Parsons Home
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth E. Hilghman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Theodore C. Hilghman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 31, 1870

8. AGE: Years	Months	Days	If less than one day
76	0	5	..... hrs. ..... min.

9. Birthplace: Wicomico, Co. Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: William Washburn

FATHER — 13. Birthplace: Wicomico Co. Md

MOTHER — 14. Maiden name: Annie Carey

MOTHER — 15. Birthplace: Wicomico, Co. Md

16. Informant: Mrs Henry Jone

Address: Eden, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/7/46 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: Shad Point, Md

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md

19. 4/7/46 (Date rec'd by registrar) 1946 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 46 at 12 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 25 19.. to Apr 5 19 46

and that I last saw h.. alive on April 1 19 46

Immediate cause of death	DURATION
Cerebral hemorrhage	10 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D., M. D. or other

Address: Salisbury Date signed: Apr 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Wanner.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

04186

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Hitch-Mrs. Robert J.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widowed

6.(b) Name of husband or wife Edith B. Hitch

6.(c) If alive, give age ← years

7. Birth date of deceased (mo., day, yr.) July 28 1873

8. AGE: Years	Months	Days	If less than one day
72	8	18	hrs. min.

9. Birthplace Wicomico co, Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Robert John Hitch

13. Birthplace Wicomico co, Md

MOTHER 14. Maiden name Sarah P Keelen

15. Birthplace Wicomico co, Md

16. Informant Howard C. Hitch

Address Salisbury, Md

17. Burial Date thereof 4/17/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wicomico Memorial Park

Location Salisbury Md

18. Funeral director The Hill & Johnson co

Address Salisbury, Md.

19. 4/17/46 (Date rec'd by registrar) Laurence E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 19 46, at 12 08 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 19 46 to April 15 19 46

and that I last saw him alive on April 14 19 46

Immediate cause of death Coronary Thrombosis — DURATION 2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J R Wanner M. D.
M. D. or other

Address Salisbury Md Date signed April

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

04187

Reg. Dist. No. 993

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7
Hospital, institution, or street address where death occurred: Peninsula Gen. Hosp
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6 Catherine St
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME Holbrook, Brinton

3. (b) Social Security Number 2

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a a	Married

6.(b) Name of husband or wife W. Laurence Holbrook
6.(c) If alive, give age no maximum years

7. Birth date of deceased (mo., day, yr.) Mar 3 1903

8. AGE: Years	Months	Days	If less than one day
43	—	—	hrs. min.

9. Birthplace Princess Anne md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Same as above

FATHER
12. Name Solomon Brittle
13. Birthplace Mt Vernon md

MOTHER
14. Maiden name Bertha Parsons Holbrook
15. Birthplace Brinton md

16. Informant Mrs Bertha Parsons
Address Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2 1940 (month) (day) (year)
Cemetery or crematory John Wesley
Location Princess Anne md
18. Funeral director James F. Stewart
Address Salisbury md

19. 5/2 1940 Thomas E. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1940, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary embolism	
Due to Cardio vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Thos A Dunlap M. D. of other
Address Salisbury, Md Date signed 5-3-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333 265

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Somerset
City or town: Crisfield (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: Holland, Mr. William E
3. (b) Social Security Number: none

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Divorced
6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): May 7, 1886
8. AGE: Years 59 | Months 11 | Days 8 | If less than one day ... hrs. ... min.
9. Birthplace: Crisfield (Town, county, and state)
10. Usual occupation: Barber
11. Industry or business: Self
FATHER 12. Name: William H. Holland
13. Birthplace: Crisfield
MOTHER 14. Maiden name: Welca Ashmead
15. Birthplace: Crisfield
16. Informant: Holly Wallace
Address: Wellman Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/17/46 (month) (day) (year)
Cemetery or crematory: Crisfield Cemetery
Location: Crisfield Md
18. Funeral director: Horace H. Hall & Johnson
Address: 4/25 1946 Crisfield Md E. Johnson
19. 4/16/46 (Date rec'd by registrar) C. E. Collins M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15, 1946, at 2:55 p.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 10 1946, to Apr. 15 1946
and that I last saw him alive on Apr. 15 1946

Immediate cause of death	DURATION
Congestive Heart Failure, Acute	
Due to	
Due to	

Other conditions: Fractured Ribs, right with Traumatic Hemothorax (Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide, or homicide~~: Undetermined Date of: uncertain
Where did injury occur? Crisfield (City or town) Somerset (County) Md (State)
Injured at ~~home, farm, industry,~~ public place (where?) Jail ??
Means of injury: Undetermined Injured at work? NO

23. SIGNATURE: I. Rives Hanson, M.D. M. D. or other
Address: Salisbury, Md Date signed: 4-16-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04189

Reg. Diat. No. 339

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 39 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Allen, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: no
(If rural, give LOCATION)

2.(a) If veteran, name war: Don't know

3.(a) FULL NAME: Jackson - George Wm.

3.(b) Social Security Number: Don't know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Don't know

6.(b) Name of husband or wife: Don't know

Don't know 6.(c) If alive, give age Don't know years

7. Birth date of deceased (mo., day, yr.): about 1884

8. AGE: Years	Months	Days	If less than one day
about 62	—	—	....hrs. ....min.

9. Birthplace: N. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER — 12. Name: Don't know

FATHER — 13. Birthplace: Don't know

MOTHER — 14. Maiden name: Don't know

MOTHER — 15. Birthplace: Don't know

16. Informant: Peninsula General Hospital

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 27-1946 (month) (day) (year)

Cemetery or crematory: Public

Location: Salisbury, Md

18. Funeral director: James H. Stewart

Address: Salisbury, md

19. 4/27/46 (Date rec'd by registrar) Katherine J. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-24 19 46, at 8 35 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....., 19.... to ....., 19.....

and that I last saw ... alive on ....., 19.....

Immediate cause of death	DURATION
Brain damage	
subarachnoid Hemorrhage	4 days
Due to: Fractured Skull	
Due to: Blow on head	11
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: .....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Hom. Homicide Date of 4-22/46

Where did injury occur? Allen (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury unknown Injured at work? No

23. SIGNATURE: Lafayette Md Hospital Examiner M. D. or other

Address: Salisbury Md Date signed 4/24/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

64190

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or Institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Mary Elemore Walles Jackson

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a. a.	married

6.(b) Name of husband or wife: Harrison Jackson (If wife, give maiden name)

6.(c) If alive, give age: yes years

7. Birth date of deceased (mo., day, yr.): about 1871

8. AGE: Years 75 | Months — | Days — | If less than one day: hrs. min.

9. Birthplace: Salisbury md (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business: Same as above

FATHER — 12. Name: Elisha Parsons

FATHER — 13. Birthplace: Salisbury md

MOTHER — 14. Maiden name: Charlott Parsons

MOTHER — 15. Birthplace: Salisbury md

16. Informant: Harrison Jackson

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 20-1946 (month) (day) (year)

Cemetery or crematory: Parsons

Location: Salisbury md

18. Funeral director: James A. Stewart

Address: Salisbury md

19. 4/20, 19 46. Received by registrar: Harriet B. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-17 19 46, at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-6 19 45, to 4-17 19 46

and that I last saw h. alive on 4-17 19 46

Immediate cause of death: Congestive Heart failure — DURATION

Due to: Arteriosclerotic hyper-tension

Due to: Chronic glomerulo nephritis

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. A. Purnell, M.D. M. D. or other

Address: 900 W. Main St. Salisbury, Md. Date signed: 4-18-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

CERTIFICATE OF DEATH

04191

Reg. Dist. No. 303

1. PLACE OF DEATH:
County: Wicomico
City or town: Powellville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new-born infants, give residence of mother)
State: Md. County: Wicomico
City or town: Powellville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henry Walter Jones

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Laura C. Jones
6.(c) If alive, give age: 69 years
7. Birth date of deceased (mo., day, yr.): Dec. 3 1867
8. AGE: Years: 78 Months: 4 Days: 22 If less than one day: hrs. min.
9. Birthplace: Powellville Md. (Town, county, and state)
10. Usual occupation: Retired Farmer and
11. Industry or business: Lumber man

FATHER
12. Name: Eli Clinton Jones
13. Birthplace: Powellville Md.

MOTHER
14. Maiden name: Clarissa Richardson
15. Birthplace: Powellville Md.

16. Informant: Mr. H. Walter Jones
Address: 214 Hazel Ave. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof April 29-1946 (month) (day) (year)
Cemetery or crematory: Bennie Cem.
Location: Powellville Md
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland

19. 4/29/46 (Date received by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1946 at 7.50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1946 to April 25 1946 and that I last saw him alive on April 25 1946

	DURATION
Immediate cause of death: Myocarditis Chronic	2 yrs.
Due to: Hypertension.	
Due to: Arteriosclerosis.	
Due to:	
Other conditions: Obesity Diabetes mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank R. Lewis M.D. M. D. or other
Address: Pittsville Md. Date signed 4-26-46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

04192

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Willards
(If outside city or town limits, writes RURAL and give nearest town)
How long in above place of death? 57 yrs.
Hospital, institution, or street address where death occurred: ✓
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Wicomico
City or town: Willards
(If outside city or town limits, writes RURAL and give nearest town)
Street No.: R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Alexia Emma Lewis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John D.H. Lewis
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Feb. 5 1866

8. AGE: Years	Months	Days	If less than one day
80	2	13	...hrs. ...min.

9. Birthplace: Maryland. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Housework.
FATHER 12. Name: John H. Brittingham
13. Birthplace: Md.
MOTHER 14. Maiden name: Eliza Johnson
15. Birthplace: Md.
16. Informant: Mrs. James Roe Shockley
Address: Pocomoke, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20 1946 (month) (day) (year)
Cemetery or crematory: Pittsville
Location: Pittsville, Md.
16. Funeral director: M. Pasha Watson
Address: Salisbury, Md.
19. (Date rec'd by registrar) 4/20/1946 Hassie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18, 1946 19... at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1945 19... to day of death 19... and that I last saw h[illegible] alive on 4-18-46 19...

Immediate cause of death	DURATION
Myocarditis Chronic	2
Due to	
Due to Hypertension	
Cerebral Hemorrhage 3 days	
Other conditions before death	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Frank R. Lewis M.D.
M. D. or other
Address: Willards Md. Date signed 4-19-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

04193

CERTIFICATE OF DEATH

Reg. Diat. No. 999

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, institution, or street address where death occurred: 117 S. Wayler St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 117 S Wayler St (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clara L. Livingston

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Irving Livingston

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Jan 2, 1884

8. AGE: Years	Months	Days	If less than one day
62	3	4	..... hrs. ..... min.

9. Birthplace: Wicomico Co, Md (Town, county, and state)

10. Usual occupation: at Home

11. Industry or business

FATHER — 12. Name: John Clayton Gordy

FATHER — 13. Birthplace: Wicomico Co, Md

MOTHER — 14. Maiden name: Laura A Brittingham

MOTHER — 15. Birthplace: Wicomico Co, Md

18. Informant: Mrs Irving Livingston

Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/19/46 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury Md

18. Funeral director: The Wirt L. Johnson Co

Address: Salisbury, Md

19. 4/19 1946 Harriet E. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 1946, at 12:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 6 1946, to Apr 6 1946 and that I last saw h... alive on Apr 6 1946

Immediate cause of death: Cerebral hemorrhage — DURATION: 1 day

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Sumner Gyn D. M. D. or other

Address: Salisbury Date signed: Apr 7

Dr. Grame

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

04194

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico Co
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution or street address where death occurred: RD #2 (or Glen St)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new-born infants give residence of mother)
State: Md County: Wicomico Co
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. RD #2 (Glen St) (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emory Clarence Lowe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Fannie Lowe
6.(c) If alive, give age: 73 years
7. Birth date of deceased (mo., day, yr.): June 4-1871

8. AGE: Years 74 | Months 10 | Days 8 | If less than one day: hrs. min.

9. Birthplace: Parsonsburg Md. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:

MOTHER FATHER
12. Name: John Lowe
13. Birthplace: Sussex Co. Del.
14. Maiden name: Sarah Palmer
15. Birthplace: Sussex Co. Del.

16. Informant: Mrs. Fannie Lowe
Address: RD #2 or Glen St. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Apr. 15 46 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.
18. Funeral director: Holloway & Waller R. Waller
Address: Salisbury Md.

19. 4/15/46 Harriet E. Johnson Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 19 46 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw him alive on 4-12-46 19 ...
Immediate cause of death: Coronary Occlusion

DURATION

Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. R. Grame M.D. (M. D. or other)
Address: Salisbury, Md. Date signed: 4-12-46

VS A15 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04195

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wor.

City or town: Ocean City Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ludlam, Lillian Alice

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1944

8. AGE:	Years	Months	Days	If less than one day
	1	4	22	..... hrs. ..... min.

9. Birthplace: Salisbury Wic Co. Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Maurice Ludlam

13. Birthplace: Md.

MOTHER

14. Maiden name: Anna Bergman

15. Birthplace: Md.

16. Informant: Mrs. Maurice Ludlam

Address: Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/19/46 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin Md

18. Funeral director: Amos D. Bunting

Address: Berlin Md

19. 4/19 (Date rec'd by registrar) 19 46 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 19 46, at 4:28 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 19 46, to April 17 19 46

and that I last saw h.. alive on April 16 19 46

Immediate cause of death	DURATION
B.P. Hemorrhage	7 days
Due to	
Due to Pulmonary	3 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Salisbury Md Date signed April 19

VS A15 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

104196

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 314

CERTIFICATE OF DEATH

Reg. Dist. No. 333

VS A15 — MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury R.D 3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 61 years
Hospital, Institution, or street address where death occurred: Delmar Road R.D 3.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury R.D 3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edgar S Parker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillie M. Parker
6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.): March 26, 1895

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
51	0	20		

9. Birthplace: Wicomico co., Md (Town, county and state)
10. Usual occupation: Retired Service Station
11. Industry or business: Filling Station & Store
FATHER 12. Name: W. Parker
FATHER 13. Birthplace: Wicomico co., Md
MOTHER 14. Maiden name: Sarah Ann Parker
MOTHER 15. Birthplace: Wicomico co., Md
16. Informant: Mrs Edgar S. Parker
Address: Salisbury Md, R.D. 3.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/23/46 (month) (day) (year)
Cemetery or crematory: Parsons Cemetary
Location: Salisbury Md
18. Funeral director: The Hill & Johnson co
Address: Salisbury Md.
19. 4/23, 1946 (Date rec'd by registrar) Margaret E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20, 1946 at 4:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1946, to April 20, 1946, and that I last saw him alive on April 20, 1946.

Immediate cause of death: Carcinoma of Prostate with Metastases. — DURATION: 0
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John H. Yeamans M.D. M. D. or other
Address: 208 Camden Ave, Salisbury, Md. Date signed April 23, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04197

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico.

City or town: Powellville. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico.

City or town: Powellville. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Margie Virginia Perdue.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married.

6.(b) Name of husband or wife: I. William Perdue

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Jan. 22, 1891

8. AGE: Years: 55 Months: 2 Days: 18 If less than one day: hrs. min.

9. Birthplace: Powellville, Wic. Co. Md. (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER 12. Name: Eli T. Jones.

FATHER 13. Birthplace: Whitesville Md.

MOTHER 14. Maiden name: Leah Nancy Adkins.

MOTHER 15. Birthplace: Powellville, Md

16. Informant: Mr. I. W. Perdue

Address: Powellville. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/13/46 (month) (day) (year)

Cemetery or crematory: Jones

Location: Powellville Md.

18. Funeral director: Anna A Bunbage

Address: Berlin Md.

19. 4/13/46 (Date received by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1946, at 10 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 45 to April 10 19 46

and that I last saw h alive on April 7 19 46

Immediate cause of death: CA of Uterus & Metastasis

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jno D Gray MD M. D. or other

Address: Salisbury Md Date signed 4/13/46

Evidence for addition of approximate age of deceased is shown on
FILM No. I O 1 APR 29 1946

04198

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (185)

CERTIFICATE OF DEATH

Reg. Dist. No. 11 336

The correct age

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Wicomico
City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)
Street No. W. East St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Henry Rice

3. (b) Social Security Number

4. Sex: Male
5. Color or race: Black
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife —
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) —

8. AGE: Years: Approx. ? 50 Months: ? Days: ? If less than one day ... hrs. ... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Labor
11. Industry or business
FATHER 12. Name: John Rice
13. Birthplace: Delmar Del.
MOTHER 14. Maiden name: Katie Dennis
15. Birthplace: Virginia
16. Informant: Flossie Johnson
Address: Laurel, Del
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-15-46 (month) (day) (year)
Cemetery or crematory: Union
Location: Delmar Del
18. Funeral director: J S Manuel Co
Address: Delmar, Del
19. 4-15-1946 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 1946, at 7 15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... medical examiner ... on ... 19...

Immediate cause of death: Burns of entire body — DURATION: sudden death
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 4/14/46
Where did injury occur? Delmar Wicomico Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: shack caught fire Injured at work? No

23. SIGNATURE: [illegible] deputy Med Examiner M. D. or other
Address: Salisbury Md Date signed 4/15/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

04199

Reg. Dist. No. 838

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Near Pittsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred:
In Woods Near Pittsville.

How long in hospital or institution? Not.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Delaware County: Kent

City or town: Dover
(If ontside city or town limits, write RURAL and give nearest town)

Street No.: Dover Army Air ~~Base~~ Field
(If rurnl, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Rosenberg, Arnold F

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 23 Nov., 1924

8. AGE: Years	Months	Days	If less than one day
21	4	22	..... hrs. ..... min.

9. Birthplace: Massachusetts
(Town, county, and stnte)

10. Usual occupation: Pilot - U.S. Army.

11. Industry or business: —

FATHER
12. Name: Benedict Bernard
13. Birthplace: Russia

MOTHER
14. Maiden name: Bertha
15. Birthplace: Russia

16. Intormant: U.S. Army Records
Address: Dover Army Air Field, Dover, Del.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: APRIL 17, 1946 (month) (day) (year)

Cemetery or crematory: CHEVRA CHAVODIM -

Location: WEST ROXBURY, MASS.

18. Funeral director: STANETSKY FUNERAL CHAPEL
BENJAMIN BIRNBACH, REG. F.D.

Address: 10 WASHINGTON ST., DORCHESTER 21, MASS

19. 6-/9/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 April 19 46 approx. at 1030 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Accidental Death to Report 19 ..... and that I last saw h... l... alive on — 19 .....

Immediate cause of death	DURATION
Dismemberment and Disemboweiment	
Due to: Violent Contact with metal parts of Aircraft.	
Due to: Aircraft crashing into trees and ground.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Aircraft Accident Date of 14 APRIL 46

Where did injury occur? (Near) Pittsville (City or town), (County), Md. (State)

Injured at home, farm, industry, public place (where?) In Woods

Means of injury: Aircraft Accident Injured at work? Yes.

23. SIGNATURE: Clara T. Fisher 2nd Medical Examiner, M.D., or other

Address: Salisbury, Md. Date signed: 4/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-B)

04200

CERTIFICATE OF DEATH

Reg. Dist. No. 333

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, Institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No. 304 Maryland ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Valerie Carol Sample

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

B.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 6, 1946

8. AGE: Years	Months	Days	If less than one day
		13	..... hrs. ..... min.

9. Birthplace Salisbury Wic. Md.
(Town, county, and state)

10. Usual occupation infant

11. Industry or business

FATHER 12. Name John Sample

13. Birthplace Delmar, Del

MOTHER 14. Maiden name Esther Davis

15. Birthplace Wilmington, Del

16. Informant John Sample

Address Delmar Del

17. Burial Date thereof 4-20-46
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Mt. P.

Location Delmar Del

18. Funeral director W.S. Harvel Co.

Address Delmar, Delaware

19. 4/20/1946 Harriet E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 18 1946 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 April 1946, to 18 April 1946

and that I last saw her alive on 18 April 1946

	DURATION
Immediate cause of death Congenital Meningocoele	13 days
Due to Spina Bifida	
Due to	
Other conditions Multiple Congenital defects	13 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Akins M.D.
M. D. or other

Address Salisbury, Md. Date signed 19 April 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04201

CERTIFICATE OF DEATH

Reg. Dist. No. 383

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, institution, or street address (where death occurred): 639 W. Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For nonresident infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 639 W. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie E. Savage

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Dead
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 5-1848

8. AGE: Years: 97 Months: 5 Days: 26 If less than one day: ..... hrs. ..... min.

9. Birthplace: Sussex Co. Del.
(Town, county, and state)

10. Usual occupation: at Home

11. Industry or business:

FATHER
12. Name: Peter Brady
13. Birthplace: Sussex Co. Del.

MOTHER
14. Maiden name: Rebecca Collins
15. Birthplace: Sussex Co. Del.

16. Informant: Mr. John Savage
Address: 639 W. Main St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 4 46 (month) (day) (year)
Cemetery or crematory: Parsonsburg Cem.
Location: near Georgetown Del.

18. Funeral director: John J. Carey
Address: Georgetown Delaware

19. 4/4/46 (Date rec'd by registrar) 1946 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1 1946 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946, to death 1946
and that I last saw h.... alive on April 1 1946

Immediate cause of death	DURATION
Cardiac Decompensation	
Due to: Arteriosclerotic C-V-R disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury, Md. Date signed 4/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-5)

04202

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 year

Hospital, Institution, or street address where death occurred: 421 Camden ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 421 Camden ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Schroder

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 10, 1870

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
75	8	4		

9. Birthplace: New York city (Town, county, and state)

10. Usual occupation: Accountant

11. Industry or business: Retired

FATHER — 12. Name: Conrad Schroder

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Not Known

MOTHER — 15. Birthplace:

16. Informant: J. Phillips Stow

Address: 421 camden ave Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/20/46 (month) (day) (year)

Cemetery or crematory: Parsons cemetary

Location: Salisbury Md

18. Funeral director: The Hitch & Johnson co

Address: Salisbury, md

19. 4/20 1946 (Date rec'd by registrar) Earle T. Ed Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1946 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1946, to April 14 1946 and that I last saw him alive on April 14 1946

Immediate cause of death	DURATION
Uremia	
Due to Hypertensive C-V-R Disease	
Due to Prostate Hypertrophy	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Salisbury Md Date signed: 4/15/46

VS A15 P-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04203

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: P. B. Hoyt
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 919 Railroad ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emory William Shockley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lavenia Shockley
If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.): Feb. 6th 1870

8. AGE: Years 76 | Months 2 | Days 10 | If less than one day: hrs. min.

9. Birthplace: P.O. Parsonsburg Md
(Town, county, and state)
10. Usual occupation:
11. Industry or business: Retired

FATHER
12. Name: Hezakeal Shockley
13. Birthplace: P.O. Parsonsburg Md.

MOTHER
14. Maiden name: Hammond
15. Birthplace: P.O. Parsonsburg Md.

16. Informant: Mr. Walter B. Shockley
Address: 314 Smith st. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 18-46 (month) (day) (year)
Cemetery or crematory: Hammond Cem.
Location: P.O. Salisbury, Maryland
18. Funeral director: Wallace R. Holloway & Co.
Address: Salisbury Maryland.

19. 4/17/46 (Date rec'd by registrar) Patrick E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16th 46 at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 19 46, to April 19 46
and that I last saw h[illegible] alive on 4-16-46 19

Immediate cause of death	DURATION
Chronic Myocarditis.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injury at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. R. Grams Jr. M.D.
M. D. or other
Address: Salisbury, Md. Date signed 4-17-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131E)

CERTIFICATE OF DEATH

04204 336

Reg. Dist. No. 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: R 7 D # 3

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 82 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. R 7 D # 3

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elisha Lewiston Sturgis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Linda Sturgis

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Oct 9 1863

8. AGE: Years	Months	Days	If less than one day
82			hrs. min.

9. Birthplace Wicomico County, Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER 12. Name Chas. H. Sturgis

FATHER 13. Birthplace Wicomico County, Md.

MOTHER 14. Maiden name Mary E. Parsons

MOTHER 15. Birthplace Wicomico County, Md

16. Informant Mrs. James Sturgis

Address Delmar, Del.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 4-10-46 (month) (day) (year)

Cemetery or ~~crematory~~ Melson

Location Delmar, Del.

18. Funeral director W. S. Grand Co

Address Delmar Del.

19. April 10, 1946 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1945, to April 7 1946, and that I last saw him alive on April 6 1946.

Immediate cause of death	DURATION
a Heart	[illegible]
Due to Chronic Myocarditis	4 yrs.
Due to Chronic Nephritis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Lynch M. D. or other

Address Delmar, Md. Date signed April 8 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04205

Reg. Diat. No. 999

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

105 E. Cherry St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town East Princess Anne, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Gordon B. Townsend

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife Maggie Townsend

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 1, 1871

8. AGE: Years 75 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Unknown (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Preston Townsend

13. Birthplace Unknown

MOTHER 14. Maiden name Narcissa Jones

15. Birthplace Unknown

16. Informant Mayor Holston

Address Naylors, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 22 1946 (Month) (day) (year)

Cemetery or crematory Olivet Cemetery

Location Worcester Co. Md

18. Funeral director Charles Washnell

Address Princess Anne, Md.

19. 4/21 1946 (Date rec'd by registrar) Harriet B. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1946 at 6 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-1 1946 to 4/20 1946 and that I last saw h.. alive on 4-20 1946

Immediate cause of death	DURATION
Arteriosclerotic nephritis	6 mos.
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Rademaker M.D. M. D. or other

Address Salisbury Md Date signed 4/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

04206

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH

County: Wicomico

City or town: Pittsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Main street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State: Md. County: Wicomico

City or town: Pittsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Main street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Isaac Henry Truitt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Truitt

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 19 1865

8. AGE:

Years	Months	Days	If less than one day
80	6	23	hrs. ____ min.

9. Birthplace: Wicomico Co. Md.

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farmer

FATHER — 12. Name: Isaac Truitt

FATHER — 13. Birthplace: Wicomico Co. Md.

MOTHER — 14. Maiden name: Jane Bettingham

MOTHER — 15. Birthplace: Sussex Co. Del.

16. Informant: Mrs. Hezekiah F. Truitt

Address: 106 Liberty St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 15-1946 (month) (day) (year)

Cemetery or crematory: Pittsville Cem.

Location: Pittsville Md.

18. Funeral director: Hillsman & C. Walter R. Hillsman

Address: Salisbury Maryland

19. 4/15/1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1946 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1945 19__ to Day of death 19__ and that I last saw him alive on Day of death 19__

Immediate cause of death	DURATION
Myocarditis Chronic	2 yrs.
Due to	
Due to	
Other conditions: Hypertension Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

IF VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Grant R. Lewis M.D.

M. D. or other

Address: Pittsville Md. Date signed: 4-12-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (44R)

CERTIFICATE OF DEATH

04207 Reg. Dist. No. 339

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Pen. Gen. Hosp.
How long in hospital or institution? 16 days 22 hrs. 5 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1708 N. Division
(If rural, give LOCATION)
2(a) If veteran, name war:

3. (a) FULL NAME: Irene Frances Waller

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Howard P. Waller
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Feb. 15th 1888

8. AGE: Years: 58 | Months: 1 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: Somerset Co. Maryland (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business: at Home

FATHER
12. Name: Thomas H. Heath
13. Birthplace: Monie Maryland

MOTHER
14. Maiden name: Louisiana Frances Nunez
15. Birthplace: Oyastein Maryland

16. Informant: Mr. Howard P. Waller
Address: 1708 N. Div. St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April (month) 14 (day) 46 (year)
Cemetery or crematory: Wicomico Mem. Park
Location: Salisbury, Maryland

18. Funeral director: Holloway & Waller R. Holloway
Address: Salisbury Maryland.

19. 4/14/46 (Date rec'd by registrar) 19 Registrar: Catherine E. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10th 19 46 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 19 46 to April 10 19 46
and that I last saw h... alive on April 10 19 46

Immediate cause of death	DURATION
Pulmonary Embolism	Sudden death
Due to: Post operative - after removal of a huge Lipo-	
Due to: Dorsoma of upper abdomen - 6 mos. (Retroperitoneal)	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: Lipo sarcoma of left upper abdomen ... Date of op. March 29/42
Autopsy results: Pulmonary Embolism - massive
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NO
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: J. A. Calender M.D.
M. D. or other
Address ... Salisbury Md. Date signed 4/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

4208

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 years

Hospital, Institution, or street, address where death occurred: 306 Hayslane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 Hayslane

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Bertha May Washburn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Louis L. Washburn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 11, 1876

8. AGE: Years	Months	Days	If less than one day
69	9	17	..... hrs. ..... min.

9. Birthplace: Wicomico co. Md

(Town, county, and state)

10. Usual occupation: at Home

11. Industry or business

FATHER — 12. Name: Levin Fields

13. Birthplace: Wicomico co, Md

MOTHER — 14. Maiden name: Catherine A. Steward

15. Birthplace: Wicomico co Md

16. Informant: Mrs Franklin Whatley

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/1/46 (month) (day) (year)

Cemetery or crematory: Shad Point Cemetery

Location: Shad Point Md

18. Funeral director: The Bell & Johnson Co

Address: Salisbury Md

19. 5/1 (Date rec'd by registrar) 19 46 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28, 1946 at 3:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 46 to April 28 1946

and that I last saw her alive on April 28 1946

Immediate cause of death: Coronary Thrombosis

DURATION: Years / Months / Days

Due to:

Due to:

Other conditions: Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Steven R Mann M. D. or other

Address: Salisbury Md Date signed 5/1/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-0)

CERTIFICATE OF DEATH

04209 Reg. Dist. No. 11

1. PLACE OF DEATH:
County Wicomico
City or town Delmar Md Side
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Twenty five years
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wicomico
City or town Delmar md
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME Beatrice A West

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a.a.	Widow

6.(b) Name of husband or wife James West
6.(c) If alive, give age no years
7. Birth date of deceased (mo., day, yr.) about 1888

8. AGE: Years	Months	Days	If less than one day
about 58	—	—	..... hrs. ..... min.

9. Birthplace Laurel Del (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Same as above
FATHER 12. Name Henry West
FATHER 13. Birthplace Laurel Del
MOTHER 14. Maiden name Nancy Evinson
MOTHER 15. Birthplace Laurel Del
16. Informant T. Franklin Gm West
Address Delmar Md Side
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 11 1946 (month) (day) (year)
Cemetery or crematory Union
Location Delmar Md
18. Funeral director James F Stewart
Address Salisbury Md
19. April 11, 1946 (Date rec'd by registrar) Harry E Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1946, at 1 30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944, to April 8, 1946 and that I last saw h.. alive on March 27, 1946

Immediate cause of death	DURATION
Chronic Myocarditis	1 1/2 years
Due to Hypertension	2 years
Due to Chronic Nephritis	Years
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE G H Lemby M D M. D. or other
Address Salisbury Md Date signed 4/11/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

Dr. Kuhlman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

04210

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 1 yr. 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Dorchester

City or town Galestown

(If outside city or town limits, write RURAL and give nearest town)

Street No. /

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wheatley M. Horace

3.(b) Social Security Number 214-16-4061

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	

6.(b) Name of husband or wife Mollie E. Wheatley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 12 1869

8. AGE: Years 76 Months 7 Days 28 If less than one day ..... hrs. ..... min.

9. Birthplace Galestown Dorchester Md

(Town, county, and state)

10. Usual occupation Marine Engineer

11. Industry or business

FATHER 12. Name Jessie P. Wheatley

13. Birthplace Md

MOTHER 14. Maiden name Mary E. Vincent

15. Birthplace Md

16. Informant Russell Wheatley

Address 726 West Olney Rd Norfolk Va.

17. Burial Date thereof 4 13 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Galestown

Location Galestown, Md.

18. Funeral director Grayson Bro

Address Sharptown

19. 4/13/46 (Date rec'd by registrar) 19.46 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 9 1946, at 2 55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 8 1946, to Apr 9 1946

and that I last saw h... alive on Apr 9 1946

	DURATION
Immediate cause of death Coronary Occlusion	20 hours.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. S. Tuckman M. D. or other

Address Sharptown Md Date signed 4/15/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

04211

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Salisbury
City or town: Wicomico
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 130 David St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Chas. Williams

3.(b) Social Security Number

4. Sex: Male
5. Color or race: Col.
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Annie Williams
6.(c) If alive, give age 58 years
7. Birth date of deceased (mo., day, yr.): Mar. 15, 1880
8. AGE: Years 61 Months Days 28 If less than one day ... hrs. ... min.
9. Birthplace: Fruitland Md (Town, county, and state)
10. Usual occupation: Labor
11. Industry or business: For; Gunby Seabrese
FATHER 12. Name: John Williams
13. Birthplace: Md
MOTHER 14. Maiden name: Dont know
15. Birthplace
16. Informant: Annie Williams
Address: 130 David St. Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 14 1946 (month) (day) (year)
Cemetery or crematory: Houston Cem. Salisbury
Location: Salisbury, Md.
18. Funeral director: C. E. Messick
Address: Pocomoke, Md
19. 4/14 1946 (Date rec'd by registrar) Hassie E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1946, at 11 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Feb 1946, to 10 April 1946
and that I last saw him alive on 10 April 1946

	DURATION
Immediate cause of death: Malignancy of Stomach	Unknown
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Arthur D. Browne M.D. (M. D. or other)
Address: Salisbury Md Date signed 4/12/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

64212

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wilomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wilomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

Street No. no
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: William Wright

3.(b) Social Security Number: 216-14-2646

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a a	Married

6.(b) Name of husband or wife: Helen Wright (Dau Thomas)

6.(c) If alive, give age: yes years

7. Birth date of deceased (mo., day, yr.): 1905

8. AGE: Years: 40 | Months: — | Days: — | If less than one day: ... hrs. ... min.

9. Birthplace: Wetipquin md
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: Same as above

FATHER 12. Name: Anthony Wright

FATHER 13. Birthplace: Wetipquin md

MOTHER 14. Maiden name: Elizabeth Cook

MOTHER 15. Birthplace: Bombay N.J.

16. Informant: Edward Cook

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 16-46 (month) (day) (year)

Cemetery or crematory: Asbury Mem

Location: Wetipquin, Md.

18. Funeral director: James T. Stewart

Address: Salisbury md

19. 4/15 1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13th 1946, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/12 1946, to 4/13 1946

and that I last saw h... alive on 4/12 1946

	DURATION
Immediate cause of death: Burns of body	8 hours
Due to: Brush fire	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 4/12 1946

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) Farm

Means of injury: Burns Injured at work? Yes

23. SIGNATURE: Elmer T. Fisher M.D.
Deputy Medical Examiner M. D. or other

Address: Salisbury Md Date signed: ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15